NOTES FROM MDCH WORK GROUP MEETING – JULY 30, 2008
CON Standard for Specialized CTs
DRAFT

Overall : There was consensus agreement on a conceptual framework for how to deal with emerging specialty CTs (copy attached), subject to agreement on the all important specifics in the Standards language. .

- Separate section of CT Standards for specialty CTs.
- Language affecting all such CTs, listing the overall requirements. Then sub-sections indicating the particularized requirements for particular types of imaging equipment (e.g., minimum volume, which professions able to have which types of units, etc.). For now this would be just separate sections for dental CTs and ENT CTs.

Agreement on Some Specific Items:

1. **Accreditation by recognized national organizations for new applicants for CTs – full body and specialty use.** Suggestion by Matt Jordan. This follows what was in the Medicare legislation that the Congress just passed over the President's veto. This gradually will also be a requirement for existing units as they upgrade/replace out-of-date equipment.
2. **Methodology for projecting that the applicant will reach the minimum volume level: (**Request Suggestion made at prior meeting by Matt Jordan.) Follow the approach already established for the first specialty use CT equipment – dental CTs. No use of data commitments based on prior referrals to existing CT units. Thus, no requirement for MDCH to determine that referral data could not be used that would result in an established full-body CT having less than minimum volume required for CON compliance. Instead, applicant would demonstrate from their own billing records for the most recent 12-month data that they treated patients with the specific listed conditions for that type of equipment.
3. **Specified patient diagnoses/treatments justifying specialty use ENT CT unit:** List on the conceptual document distributed at the meeting **(copy attached)** was only illustrative; clearly other conditions. To be specified by verbal descriptions of CPT and/or diagnostic codes, along with numeric ranges. That allows refinement of those codes to be automatically included in the list of approved conditions/treatments.
4. **Objective: Draft Language:** Language will be drafted based on the concepts agreed to at the 7/30/08 discussion.

Key Item to be Resolved at Meeting #2 Minimum Annual Volume—Prior discussions lead to suggestion of 1,500 annual minimum volume. This was based on thought that applicant for ENT CT until should be a group practice of two active otolaryngologists (ENT doctors). That was based on the premise of a minimum of 3 a day for each practitioner. So that results in 6 a day for the two, 30 per week, 1500 per year (allowing for the fact that holidays would result in equivalent of 50 weeks per year). Subsequently MDCH has spoken to Dr. Schwarz who stated that the number actually used should probably be lower; he suggests getting counsel from other otolaryngologists whether the premise of 3 a day is too high as a minimum average.

OTHER :

There was also discussion regarding the use of dental ct for orthodontics. Two points of view were presented. The first is that this issue has already been addressed by the Commission and no new information has been presented to support making changes. The second point of view is

that at the time the orthodontics issue was discussed, the primary concern was to avoid any "slippery slope" of a proliferation of specialty ct units. As the workgroup is discussing specialty CTs in a broader context, it was suggested that the concern with a "slippery slope" should no longer be the primary issue. Melissa Cupp will contact with Dr. Brooks for more recent/current information on this topic and will share it with the group.